

## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Beessie Barham</b>			2a DATE OF DEATH MONTH <b>9</b> DAY <b>24</b> YEAR <b>80</b>			2b HOUR <b>8:24</b> PM				
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH <b>9</b> DAY <b>26</b> YEAR <b>01</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.				
10 CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp</b>				12a USUAL OCCUPATION (TYPE OF WORK OR LINE OF WORKING LIFE) <b>None</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Const.</b>		
13a STATE <b>Maryland</b>			13b COUNTY <b>Howard</b>		13c CITY OR TOWN <b>Columbia</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>5586 Stevens forest Apt 4</b>	
14 FATHER'S NAME FIRST <b>Jacob</b> MIDDLE <b>Serper</b> LAST <b>Serper</b>			15 MOTHER'S MAIDEN NAME FIRST <b>Sonia</b> MIDDLE <b>Baizer</b> LAST <b>Baizer</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b SOCIAL SECURITY NO. <b>125 10 2542A</b>		17 INFORMANT <b>6402 D 16th Street N.W. Frances E. Coley Washington, D.C. 20012</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>metastatic bladder cancer</b>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>9/24/80</b> to <b>9/24/80</b> , that (1) (we) lost saw the deceased alive on <b>9/24/80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Alan G. Stahl, MD</b>			22c. ADDRESS <b>for Dr. C. Taylor</b>			22d. DATE SIGNED <b>9/24/80</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alan G. Stahl, MD</b>			22e. ADDRESS <b>for Dr. C. Taylor - Columbia Med Hse</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/26/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION CITY OR TOWN <b>Elkridge</b> COUNTY <b>Howard</b> STATE <b>Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>SLACK Funeral Home, Ellicott City, Md. 21043</b> ADDRESS _____					25a. DATE REC'D. BY REGISTRAR <b>SEP 30 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Rufus McRae</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

[illegible]



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 6 1 0  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES T. BECK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/17/80</b>		2b. HOUR <b>1:03A</b>						
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 6, 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Director</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>County Gov't.</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>P.G. Co.</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12607 Cedarbrook Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leo T. Beck</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth M. Breen</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WWII &amp; Korea 277-20-0833</b>		17. INFORMANT ADDRESS <b>Hermine R. Beck (Wife) - Same as #13.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>cardiogenic shock.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>410 -</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

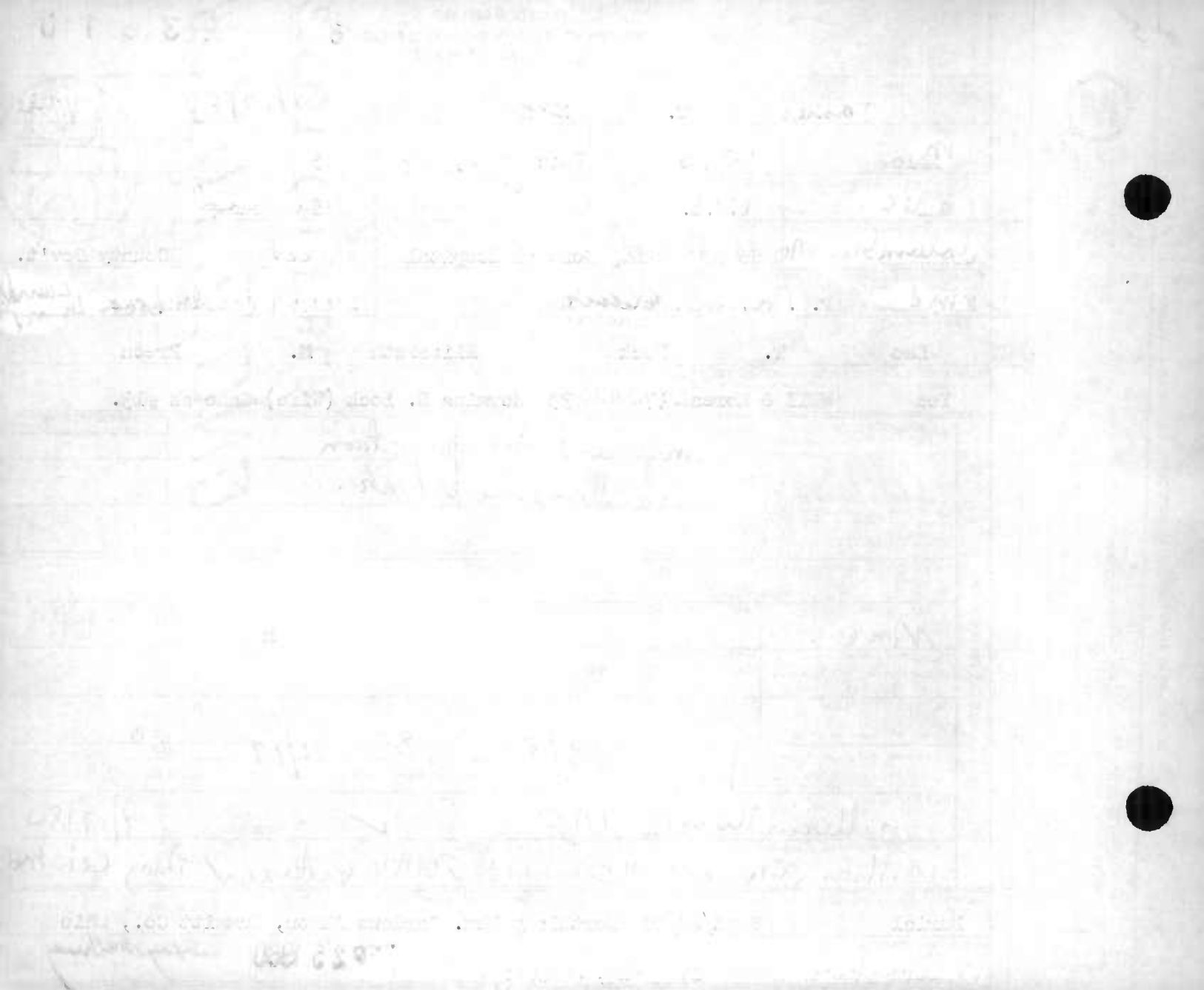
19a. DATE OF OPERATION <b>None.</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8:30 P.M. 9/17/80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1108 52 Little Patuxent Pkwy Col. Md</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/17/80</b> to <b>9/17/80</b> , that (I) (we) last saw the deceased alive on <b>8/17/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William Flowers MD</b>						22c. DATE SIGNED <b>9/17/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Flowers MD</b>				22e. ADDRESS <b>1108 52 Little Patuxent Pkwy Col. Md</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept/20/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Northlawn Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Akron, Summitt Co., Ohio</b>	
24. FUNERAL DIRECTOR NAME <b>Chambers Funeral Home Riverdale, Maryland</b>				25. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>SEP 25 1980</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page # 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOUR	
MARTHA S. BLOOM		09 12 80		10:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	WHITE	MONTH DAY YEAR	78 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		HOWARD COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
ELLICOTT CITY	4657 LEISURE COURT	SUPERVISOR	DEPT. STORE		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MARYLAND	HOWARD	ELLICOTT CITY	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4657 LEISURE COURT, 21043	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
HENRY C. SHAFER	MARTHA J. RHINEHART				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
NO	217-10-3157	MERIAM B. HELFERSTAY	4657 LEISURE COURT		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1990 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMATOSIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
KEITH FALCAO, M.D.	M.D.				9.15.80
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
KEITH FALCAO, M.D.	3350 WILKENS AVENUE, 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL	09-16-80	LOUDON PARK	BALTIMORE CITY MARYLAND		
24. FUNERAL DIRECTOR NAME	ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME, INC.	4107 WILKENS AVE.		SEP 15 1980		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 3 6 1 2

1- FOR  
STATE  
REGISTRAR

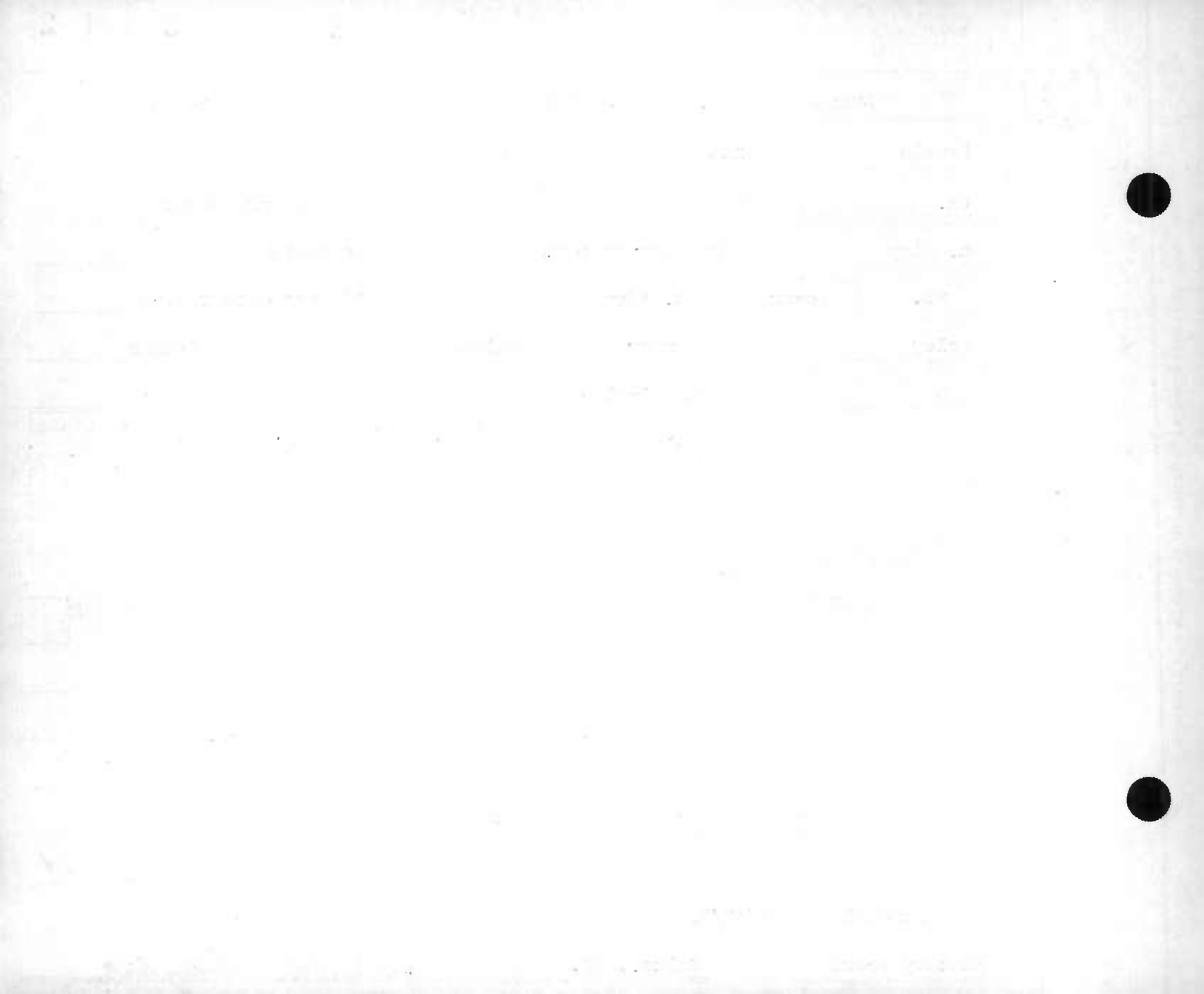
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LUELLA M. BROOKING</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 27 80</b>			2b. HOUR <b>M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 19 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7c. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Mt. Airy</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>826 Long Corner Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>826 Long Corner Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wesley McCrory</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Daisey Jacobs</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-12-9148</b>			17. INFORMANT ADDRESS				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PROBABLY MYOCARDIAL INFARCTION</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>NA</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>JULY 9</b> , 19 <b>80</b> , to <b>PRESENT</b> , that (I) (we) lost saw the deceased alive on <b>JULY 14</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Reynaldo P. Madruen, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>9/27/80</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1980</b>	
						25b. REGISTRAR'S SIGNATURE <b>P. J. Jacobs</b>	





It- 4 G 548 10/14/80 GB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 6 1 3  
CERTIFICATE OF DEATH

1- STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH	
FIRST MIDDLE LAST (Caughy) Patrick Henry Caughy		MONTH DAY YEAR 9-30-80	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)
M	White	MONTH DAY YEAR 10 13 93	86 YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH
Balto. Md.	U S		Howard County MD.
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Columbia	Howard County General Hosp		Retired
13a STATE		13b COUNTY	13c STREET ADDRESS
MD	Howard	Columbia	3017 Greenway Dr.
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST John Caughy		FIRST MIDDLE LAST Elizabeth McMahon	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
yes 1918		215 01 1566	3017 Greenway Drive Ellicott City Md. Mrs. Anna R. Caughy 21043
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 5070 DUE TO, OR AS A CONSEQUENCE OF (b) ASPERATION PNEUMONIA 48 hrs. DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) A.S.C.V.D			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22c. DATE SIGNED	
22b SIGNATURE [Signature] DEGREE		22e. ADDRESS 9055 CHEVROLET, ELLICOTT CITY, MD 21043	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARRY I. LEVINE MD		22f. ADDRESS 9055 CHEVROLET, ELLICOTT CITY, MD 21043	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Oct. 3, 1980	New Cathedral Cem.	Balto. Md.
24. FUNERAL DIRECTOR G. Truman Schwab 5151 Balto. National Pike Balto. Md. 21229		25a. DATE RECEIVED BY REGISTRAR OCT 6 1980	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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(County)  
Patrick Henry

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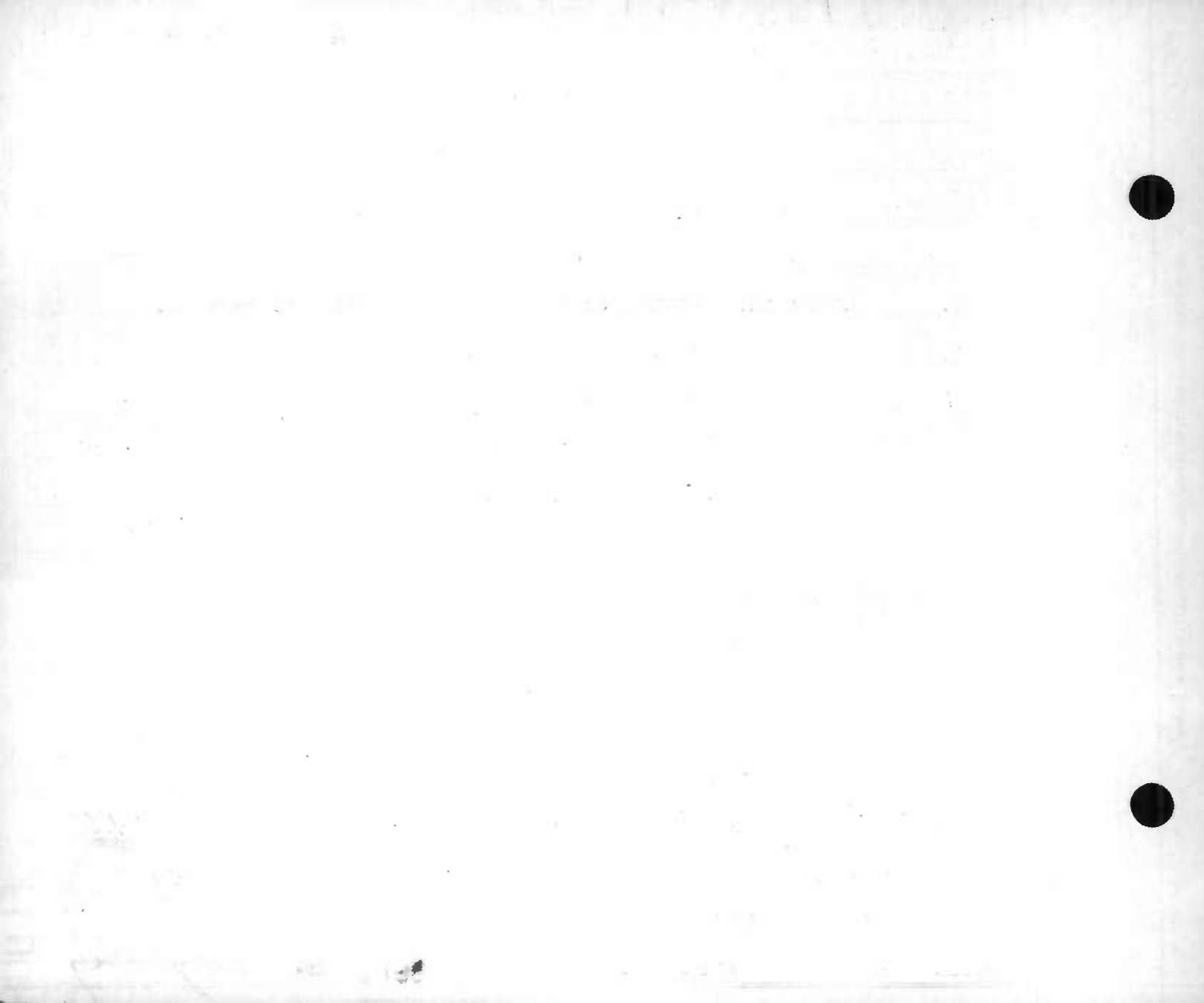
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 3 6 1 4	
Info. added per phone call 1- STATE REGISTRAR w/Anatomy Bd. 9/30/80 re										CERTIFICATE OF DEATH	
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Amy B. Collings</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>9/24/80</u>			2b. HOUR <u>2:05 PM</u>			
3 SEX <u>Female</u>		4 RACE <u>Caucasian</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>6/10/93</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>87 yrs.</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>ENGLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>HOWARD</u> MD.					
10 CITY OR TOWN OF DEATH <u>COLUMBIA</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOWARD COUNTY GENERAL HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>RET.</u>		12b. KIND OF BUSINESS OR INDUSTRY —			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <u>MD.</u>		13b. COUNTY <u>HOWARD CO.</u>		13c. CITY OR TOWN <u>ELLICOTT CITY</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>8412 West Grove Rd.</u>			
14 FATHER'S NAME FIRST MIDDLE LAST <u>Charles Collins</u>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Amelia Unknown</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>212-64-8001</u>		17 INFORMANT ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>4912</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC BRONCHITIS / EMPHYSEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>YRS.</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CONGESTIVE HEART FAILURE</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>1975</u> , 19____, to <u>9.24.80</u> , 19____, that (I) <del>(was)</del> lost saw the deceased alive on <u>9.24.80</u> , 19____, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(do not)</del> view the body after death.											
22b. SIGNATURE <u>TA Dadisman Jr</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>9.24.80.</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>TA DADISMAN JR</u>				22e. ADDRESS <u>5499 HARVARD FARM RD COLUMBIA MD 21044.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		23b. DATE <u>9/24/80</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
24 FUNERAL DIRECTOR NAME <u>Anatomy Board</u>				ADDRESS <u>Balto., Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 1 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Henry McNeely</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

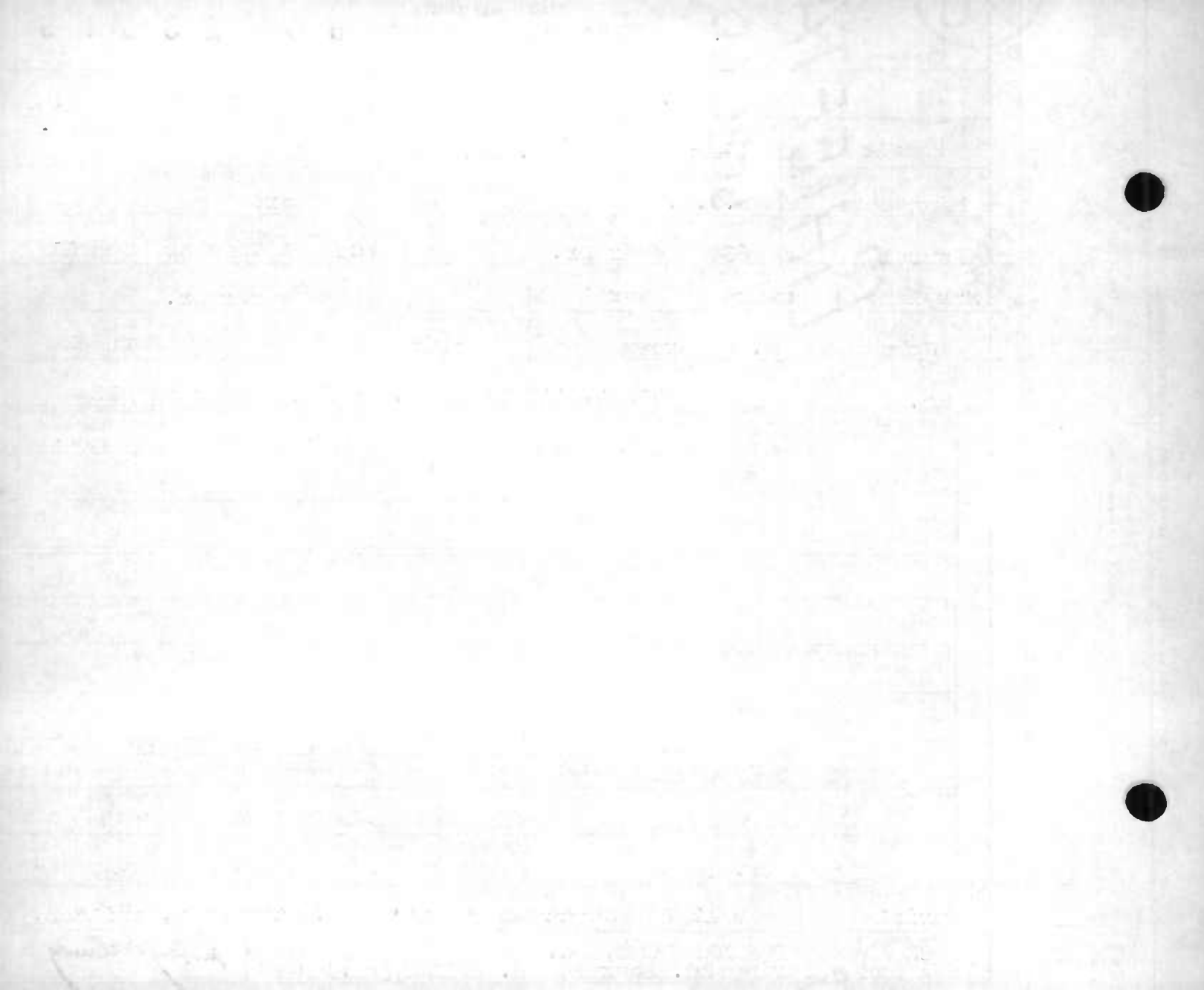
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 3 6 1 5			
1 - FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
Edna		A.				Daniels		9		9	80	12 A M	
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Apr. 16, 1888				92		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH				MD	
Minnesota		U.S.A.						Howard					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Laurel		8634 Tower Dr.				School Teacher		School					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS					
Maryland		Howard		Laurel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8634 Tower Dr.					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME											
John		M.		Brown		Maria		Borhick					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS							
No.		472-07-8777		David J. Daniels		same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		immediate	
4276													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>													
22a I certify that (I) (this hospital) attended the deceased from <u>Aug 20</u> , 19 <u>80</u> , to <u>Aug 20</u> , 19 <u>80</u> , that (I) (we) lost													
saw the deceased alive on <u>Aug 20</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE		DEGREE				22c DATE SIGNED							
Janet S. Ciarkowski		M.D.				9-9-80							
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS											
Janet S. Ciarkowski		5999 Harger's Farm Rd. Columbia. Md.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION							
Burial		9/12/80		Chattanooga Nat'l		Chattanooga, Hamilton							
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE							
FLECK LAUREL FUNERAL HOME, INC.		7601 Sandy Spring Rd. Laurel, Md. 20810				SEP 10 1980							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 0 2 3 6 1 6				
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) ARTHUR C DUMLER SR.			2a. DATE OF DEATH MONTH DAY YEAR 9 30 80		2b. HOUR 950 A.M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 26 10		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.			
10. CITY OR TOWN OF DEATH ELICOTT CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10212 CABERY ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. CITY OR TOWN HOWARD					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 10212 CABERY ROAD		
14. FATHER'S NAME JOHN H DUMLER					15. MOTHER'S MAIDEN NAME THERESA M NITSCH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1WWII		17. INFORMANT WIFE		ADDRESS AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) PROSTATIC CARCINOMA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/1 19 80 to 9/30 19 80, that (I) <del>last</del> saw the deceased alive on 9/24 19 80, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did not</del> view the body after death.									
21b. SIGNATURE Andrew R. McCullough					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 9/30/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW R. MCCULLOUGH					22e. ADDRESS DEPT. OF UROLOGY JOHNS HOPKINS HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct 3, 1980		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Maryland		
24. FUNERAL DIRECTOR NAME WITZKE, HARRY					ADDRESS 4112 COLUMBIA ROAD		25a. DATE REC'D. BY REGISTRAR OCT 6 1980		
25b. REGISTRAR'S SIGNATURE R. J. McBrady									







1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 6 1 7  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MINNETTA C. DURRIN			2a. DATE OF DEATH MONTH DAY YEAR 9-16-80		2b. HOUR 350 PM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 10-8-1882		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.	
10. CITY OR TOWN OF DEATH Columbia, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORIE NSG Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired owner millinery shop		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Conn.		13b. COUNTY Norwalk	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 28 Adams Ave.,	
14. FATHER'S NAME FIRST MIDDLE LAST late John D. Hyatt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Anne M French		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 041 30 9183	17. INFORMANT ADDRESS Mrs R. Teresz LaRoque 3605 Grosvenor Dr. Ellicott City		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anorexia, wt. loss, inanition. 2639 DUE TO, OR AS A CONSEQUENCE OF (b) FETAL ? Placental abruption or Primary Occult Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Semi-literate Ascard. Mild chronic renal failure, CHF (Dysrhythmia for Comp. Post.)					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-9-1979, to 9-16-1980, that (I) (we) last saw the deceased alive on 9-2-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Divakaruni		DEGREE MD		22c. DATE SIGNED 9-16-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. DIVAKARUNI		22e. ADDRESS 11085 Little Patuxent Pkwy Columbia MD 21044			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 19 '80		23c. NAME OF CEMETERY OR CREMATORY Greenwich Cemetery	
23d. LOCATION CITY OR TOWN Greenwich New York		COUNTY New York		STATE	
24. FUNERAL DIRECTOR NAME Harry H Witzke		ADDRESS 4112 Columbia Rd Ellicott City		25. DATE REC'D BY REGISTRAR SEP 19 1980	
26. REGISTRAR'S NAME M. J. Brady		27. REGISTRAR'S ADDRESS M. J. Brady			

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Registered owner military shop

SD Adams Ave.

John Louis D. Ignat

001 30 2185 Mrs R. Lyons LaRue 3005 Broadway St. Millbrook City

Manhattan New York

Dept 12 10 Greenwich Cemetery

Emile

SEP 1 1950

Harry N. Wilson 1112 Columbia St Millbrook City



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 1/76  
(VR A 15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 3 6 1 8					
1- FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH+ MONTH DAY YEAR				2b. HOUR	
PEARL					A. GRANT					9 12 80				450 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		BLACK		MONTH DAY YEAR 11 5 13			66			MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
VIRGINIA		UNITED STATES						HOWARD CO. MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
COLUMBIA, MD				HOWARD COUNTY GENERAL HOSP.				DOMESTIC			PRIVATE				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>		6150 FORELAND GARTH # 217							
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST					FIRST MIDDLE LAST										
ANTHONY DENNY					CORA WILLIAMS										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.			17. INFORMANT							
NO					579-32-5775A			COLUMBIA, MARYLAND GARLAND MITCHELL/5485 LUCKPENNY AVE.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> <u>436-</u> DUE TO, OR AS A CONSEQUENCE OF b) <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF c) <u>MANY YEARS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9/8</u> , 19 <u>80</u> , to <u>9/12</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9/12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>John J. Blanch, MD</u>						DEGREE			22c. DATE SIGNED						
						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			9/12/80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN J. BLANCH, MD (FOR CHARLES E. TAYLOR M.D.)</u>						22e. ADDRESS <u>PATUXENT MEDICAL GROUP</u> <u>5999 HARPERS FARM RD.</u> <u>COLUMBIA, MD 21044</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE						
BURIAL				9-16-80		2nd BAPTIST CHURCH CHURCH CEMETERY			FALLS CHURCH VA.						
24. FUNERAL DIRECTOR NAME <u>ROLLINS</u>						25a. DATE REC'D. BY REGISTRAR (SEAL REGISTRAR'S SIGNATURE) <u>WASH. D.C.</u> <u>WASHINGTON, D.C.</u>			25b. DATE REC'D. BY REGISTRAR (SEAL REGISTRAR'S SIGNATURE) <u>SEP 15 1980</u> <u>Rollins</u>						



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NEW YORK, N.Y. 10003

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LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 1, 14, 15 G 548 10/1/80 GB									
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Paul Davidson Hahn Sr.</b>					2a. DATE OF DEATH MONTH <b>9</b> DAY <b>18</b> YEAR <b>80</b>				
3 SEX <b>male</b>					2b. HOUR <b>7:30</b> AM				
4 RACE <b>Caucasian</b>					5 DATE OF BIRTH MONTH <b>1</b> DAY <b>17</b> YEAR <b>58</b>				
6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS					7. BIRTHPLACE (STATE OR FOREIGN) <b>Indiana</b>				
8. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD				
10. CITY OR TOWN OF DEATH <b>Columbia</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired school teacher</b>					12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>M.D.</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Columbia</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>Peacock</b> LAST <b>Hahn</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Lula</b> MIDDLE <b>Jane</b> LAST <b>Hahn</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. <b>577-28-6847</b>				
17. INFORMANT ADDRESS <b>Columbia Md</b>					17. INFORMANT <b>Mrs David Martorana</b> <b>6613 Seneca Dr.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <b>Septic Shock</b>									
2387									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>myeloproliferative Disorder</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pancytopenia</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>NONE</b>									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>1973</b> to <b>17 Apr</b> 19 <b>80</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>17 Apr</b> 19 <b>80</b> , and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Francis Bruno</b> DEGREE <b>MD</b>									
22c. DATE SIGNED <b>9-18-80</b>									
22d. ADDRESS <b>Columbia, Md 21044</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>									
23b. DATE <b>Sept 20 '80</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>Nat'l Memorial Park</b>									
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fall Church Virginia</b>									
24. FUNERAL DIRECTOR NAME <b>Harry H Witzke</b> ADDRESS <b>4112 Columbia RD Ellicott City</b>									
25a. DATE REC'D. BY REGISTRAR <b>SEP 22 1980</b>									
25b. REGISTRAR'S SIGNATURE <b>notary/ke...</b>									



U.S.A.

Noted school teacher

From [illegible]

John [illegible]

Columbia St.

Mrs David [illegible] 653 Benson Dr.

*Handwritten notes:*  
The [illegible]  
[illegible]  
[illegible]



12 1/2

*Handwritten notes:*  
[illegible]  
[illegible]  
[illegible]

Sept 20 1950 [illegible] [illegible]

Harry H. Wierke with Columbia St. [illegible] 251 2 1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 6 2 0  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Winifred Mary Hammond		2a. DATE OF DEATH MONTH DAY YEAR Sept. 6, 1980	
3. SEX Female		2b. HOUR 7 A. M.	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR Oct. 5, 1905		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.	
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3628 Fels La.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Court	
13a. STATE Md.		13b. COUNTY Howard	
13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3628 Fels La.			
14. FATHER'S NAME FIRST MIDDLE LAST Martin F. Burke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriett Sweeny	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213 01 6914	
17. INFORMANT ADDRESS Arthur Hammond, Sr. Ellicott City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>UTI</u> (c) <u>Lung Carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 10 days 4 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF FIRMER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/16</u> 19 <u>80</u> to <u>9/6</u> 19 <u>80</u> that (I) (we) last saw the deceased alive on <u>9/4</u> 19 <u>80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE <u>William C Waterfield MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) William C Waterfield		22d. ADDRESS 900 CATON AVE BALT MD 21043	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-10-80	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Harry W. Haight		25a. DATE REC'D. BY REGISTRAR SEP 15 1980	
25b. REGISTRAR'S SIGNATURE P. J. McCready			

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 0 2 3 6 2 1									
1. DECEASED NAME (TYPE OR PRINT) <b>OTIS C. HODGES</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9-2-80</b> 2b. HOUR <b>11 A.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 13, 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County Gen. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dry Wall Cont.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6513 MARVIN AVE.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Roby Hodges</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Missouri Baird</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>241 34 8081</b>		17. INFORMANT ADDRESS <b>Georgia Hodges Sykesville, Md.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> <b>410 -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ANTERIOR SEPTAL MYOCARDIAL INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>± 20 HOURS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 1</b> , 19 <b>80</b> , to <b>SEPT 2</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>SEPT 2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Ronald H. Parks</b>					DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9/2/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RONALD R. PARKS</b>					22e. ADDRESS <b>11065 LITTLE PAT. PRUEY COL. MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-5-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Carroll Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b> ADDRESS <b>Sykesville, Md.</b>					25. DATE REC'D. BY REGISTRAR <b>SEP 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Harry W. Haight</b>		

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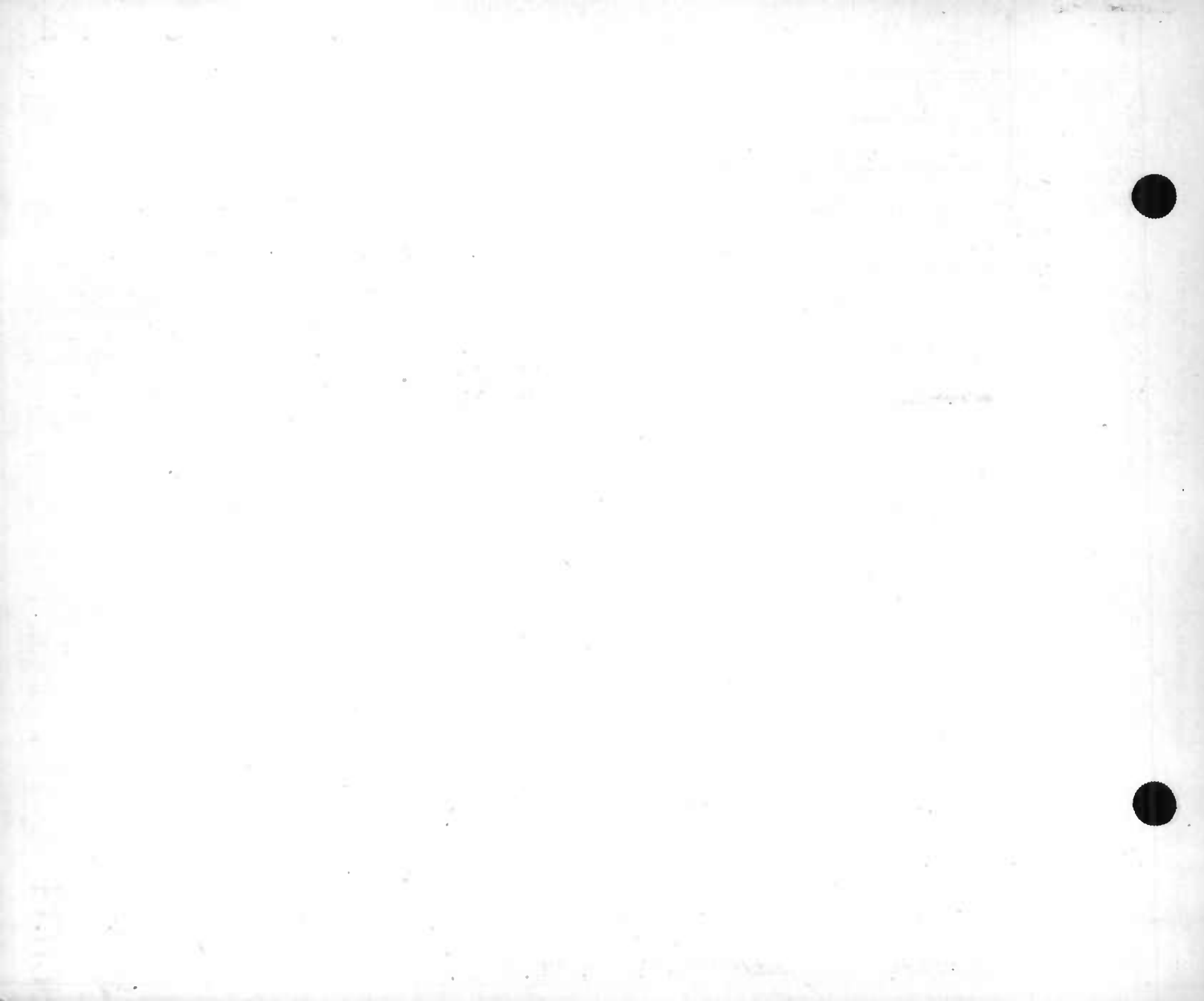
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 3 6 2 2			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Virginia Dare Howell</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>Sept. 11 80</u>		2b. HOUR <u>1115p.m.</u>	
3 SEX <u>female</u>		4 RACE <u>Black</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>Aug. 24 50</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>30</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Winterville, N.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Howard County</u> MD.	
10 CITY OR TOWN OF DEATH <u>Columbia</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Howard County General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Systems manager</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD.</u>		13b. COUNTY <u>Howard</u>		13c. CITY OR TOWN <u>Columbia</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>Boston Vine</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Rubinea Corbett</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>241-86-5065</u>	
16c. ADDRESS <u>5421 El Camino Rd.</u>		16d. ADDRESS <u>5421 El Camino Rd.</u>		16e. ADDRESS <u>5421 El Camino Rd.</u>		16f. ADDRESS <u>5421 El Camino Rd.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OVARIAN CARCINOMA</u> <u>1830</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <u>he</u> (this hospital) attended the deceased from <u>9-10</u> , 19 <u>80</u> , to <u>9-11</u> , 19 <u>80</u> , that <u>he</u> (we) last saw the deceased alive on <u>9-11</u> , 19 <u>80</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>that</u> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert S. Goodwin</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>9-15-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT S. GOODWIN, MD</u>				22e. ADDRESS <u>HOWARD COUNTY GENERAL HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL/BURIAL</u>		23b. DATE <u>09/15/80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BROWN HILL CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>GREENVILLE NO. CAR.</u>	
23e. NAME OF CEMETERY OR CREMATORY <u>PHILLIPS MORTUARY/GREENVILLE, SO. CAR.</u>				23f. DATE REC'D. BY REGISTRAR <u>SEP 15 1980</u>		23g. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP \_\_\_\_\_



BP  
DHMH - 17  
(V.R. 115 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										0 2 3 6 2 3	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Carl James Hutchinson</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 14 1980</b>		2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 31, 1932</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>47 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 14 1980</b>		7d. HOUR <b>9:00P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Columbia</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>const.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodstock</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>7001 Wrights Mill Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Hutchinson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>				17. INFORMANT <b>7001 Wrights Mill Road</b> <b>Lennie Merle Woodstock, Maryland 21163</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>?</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Ruptured aneurysm of basilar artery</b> IMMEDIATE CAUSE (a) <b>4300</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) <b>Deputy Chief</b> M.D. MEDICAL EXAMINER DATE SIGNED <b>9/15/80</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>				23b. DATE <b>9/18/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Balto., Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>SLACK Funeral Home, Ellicott City, Maryland 21043</b>				25a. DATE <b>SEP 22 1980</b>		25b. RE <b>Anthony M. Brady</b>					



TO: SAC, NEW YORK

DATE: 1/11/61

RE: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

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RECEIVED NEW YORK

NEW YORK OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 2 3 6 2 4			
1- FOR STATE REGISTRAR										REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) G. NORMAN Iglehart					2a DATE OF DEATH MONTH DAY YEAR 9 20 80				2b HOUR 3 45 PM				
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 2 27 02		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN			
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b CITIZEN OF WHAT COUNTRY? U.S.A.		10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.							
10 CITY OR TOWN OF DEATH Columbia, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen. Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) nurseryman		12b KIND OF BUSINESS OR INDUSTRY self employed					
13a STATE Maryland		13b COUNTY Howard		13c CITY OR TOWN Ellicott City		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 9105 A Town & Country Blvd.					
14 FATHER'S NAME FIRST MIDDLE LAST James W. Iglehart					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carline A. Gerwig								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b SOCIAL SECURITY NO. 215 24 5099A		17 INFORMANT 9105 A Town & Country Blvd. Bertha S. Iglehart Ellicott City, Md. 21043						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>410 -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Cardiovascular disease</u> (c) <u>Acute myocardial infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma prostate</u>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>80</u> , to <u>9/20</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>9/20</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE B.H. Minchew M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/20/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) B.H. Minchew						22e ADDRESS 4051 BALT. NATL. PIKE Ellicott City, Md. 21043							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b DATE 9/22/80		23c NAME OF CEMETERY OR CREMATORY Grace Epis. Cem.			23d LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, Maryland					
24 FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Md. 21043						25a DATE REC'D. BY REGISTRAR SEP 23 1980		25b REGISTRAR'S SIGNATURE J. H. Brady					

BP

Research Company

## Introduction

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## Security

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6. *Erigeron annuus* (L.) Link.

Grasshopper

Entered

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DATE: 11/14/2010 TIME: 10:00 AM



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DHMH - 17  
(VR A15 ME (5))  
15M 7/76

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE NOTED IN THE "REMARKS" SECTION OF THE CERTIFICATE. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 3 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PEELTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL CREMATION OR REMOVAL.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				6023625 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH DAY YEAR		2b. HOUR			
Albert M. Ingels								<input checked="" type="checkbox"/> 9 13 1980				M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		White		1 10 02		78 YRS.						9 14 1980		3:20 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
PENNSYLVANIA		U.S.A.				Howard County, MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Elkridge		6305 Old Washington Road		SECURITY OFFICER		WESTINGHOUSE									
USUAL RESIDENCE (IF IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
MARYLAND		HOWARD CO.		ELKRIDGE				YES		6305 OLD WASHINGTON RD.					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
ALBERT C. INGELS		UNKNOWN													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
YES		1920-1922		207-07-5794		RICHARD J. INGELS		16235 CARRS MILL RD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio cerebral injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
8809															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9 13 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6305 Old Washington Blvd. Elkridge, Howard, MD											
22. I certify that I took charge of the remains described above, held on: death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy Chief		DATE SIGNED		9/15/80									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
Thomas D. Smith, M.D.		111 Penn St. Balto., MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL		9-17-80		MEADOWRIDGE MEM. PARK		ELKRIDGE HOWARD MD.									
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
HUBBARD FUNERAL HOME INC. 4107 WILKENS AVE.		SEP 17 1980		[Signature]											



UNITED STATES

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT CAREY JACOBUS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 20, 1980</b>		2b. HOUR <b>11:55</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 1, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b>			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6604 Fortnight Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Underwriter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6604 Fortnight Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lemuel Jacobus</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise Douglas</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>076-03-2383</b>		17. INFORMANT <b>Columbia, Maryland 21044</b>		17. INFORMANT <b>Mr. Ralph Bean, 6271 Sunny Spring</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>metastatic disease to Bone</b> (c) <b>metastatic disease to Bone</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (i)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>7/25/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of Lung</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (the hospital) attended the deceased from <b>12/11</b> , 19 <b>79</b> , to <b>9/19</b> , 19 <b>80</b> , that (1) (the) last saw the deceased alive on <b>9/15</b> , 19 <b>80</b> , and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Francis Bruno</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/22/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Francis Bruno</b>				22e. ADDRESS <b>Suite 104, Med. Arts Bldg, Columbia, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9/22/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Balto., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Witzke Funeral Home of Catonsville, P.A. 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 22 1980</b>		25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



East Knight Road

Continuation of map  
of the area

Continuation of map

1/21/80

9/19/80

and

Western Avenue

1980

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 6 2 7  
CERTIFICATE OF DEATH

FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Brenda M. Janney</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9 6 80</b> 2b HOUR <b>3 A M</b>	
3. SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 16, 1890</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.		10. CITY OR TOWN OF DEATH <b>Clarksville</b>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7346 Pindell School Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13b. STREET ADDRESS <b>7346 Pindell School Road</b>		13c. CITY OR TOWN <b>Clarksville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Hopkins</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Milne</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clarksville, Md</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MYOCARDIAL FAILURE</b> <b>4/140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (the hospital) attended the deceased from <b>JULY 19 73</b> to <b>SEPT 6 19 80</b> , that (I) (we) lost saw the deceased alive on <b>SEPT 4 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22a. SIGNATURE <b>Charles S. Whitaker, M.D.</b>		22b. DATE SIGNED <b>9-6-80</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES S. WHITAKER, M.D.</b>		22d. ADDRESS <b>5540 TEN OAKS RD. CLARKSVILLE MARYLAND 21029</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9/8/80</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Balto., Md</b>	
24. FUNERAL DIRECTOR NAME <b>Witzke Funeral Home of Catonsville, P.A. 21228</b>		25. DATE REC'D. BY REGISTRAR <b>SEP 8 1980</b>	

25b. REGISTRAR'S SIGNATURE  
*Robert M. Brady*

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FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				8 0 2 3 6 2 8		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edgar Danielson Jones						2a. DATE KNOWN OF DEATH ESTI- MATED 9.22 19 80		2b. HOUR 1 30 P M	
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York state		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County		10. CITY OR TOWN OF DEATH Columbia	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trea. Dept.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.					
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE (CITY LIMITS?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6621 Allen Lane (21045)	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gussie Danielson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W W 1		17. INFORMANT 7 Hamilton Street Eleanor Bleaux Plattsburgh, N.Y. 12901					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest 4292 } Conditions, if any, which } gave rise to immediate } cause (a) stating the under- } lying cause last. } (b) Arterio-sclerotic Cardio Vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Thomas F. Herbert		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 9.22 80			
EXAMINER'S NAME (TYPE OR PRINT) Thomas F. Herbert		ADDRESS Ellicott City, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/24/80		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, Maryland			
24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043		25a. DATE SEP 26 1980		25b. REGISTRAR'S SIGNATURE Mickey McBrady					

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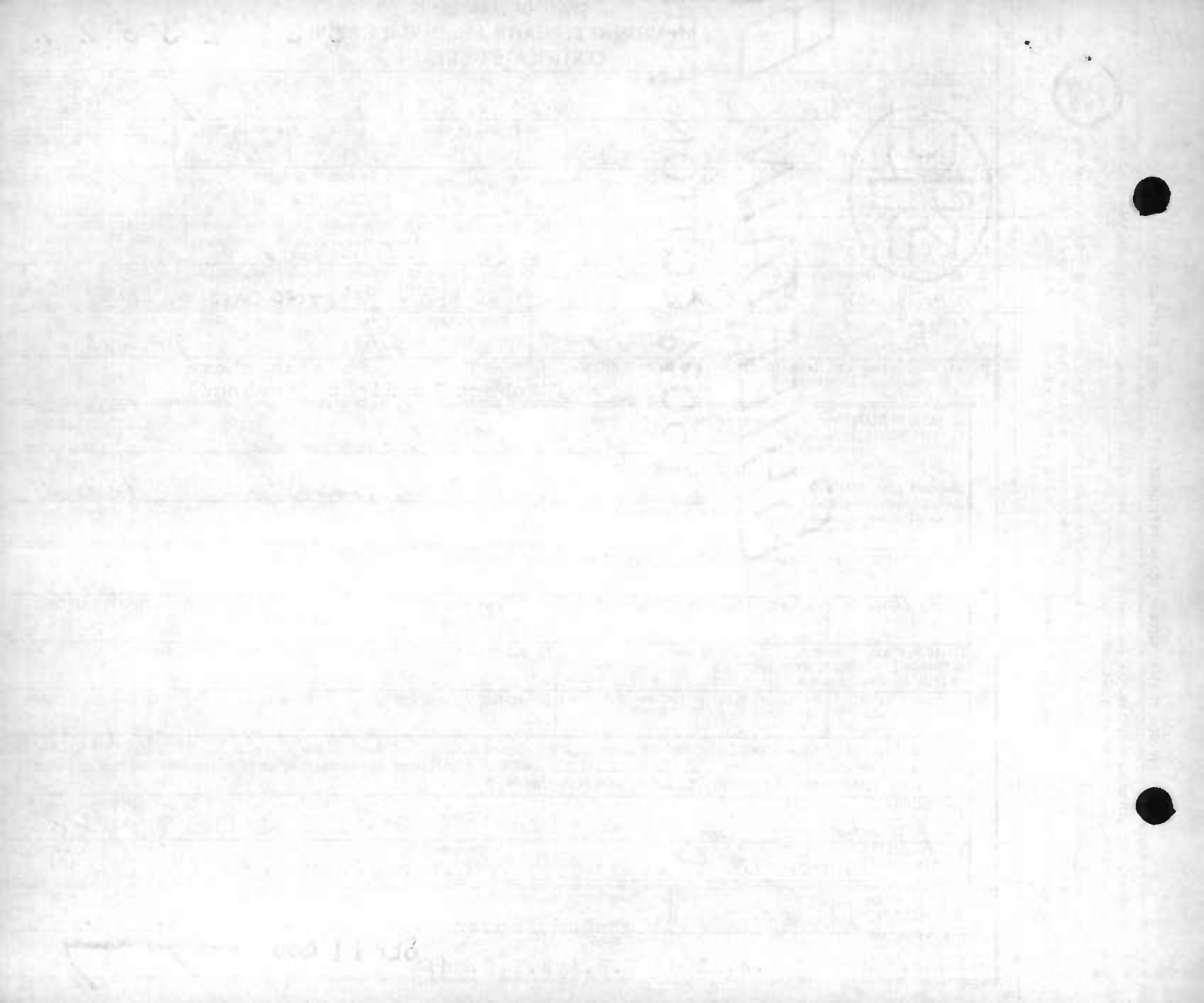
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 3 6 2 9

1. DECEASED-NAME (Type or print) <b>VIOLA FREY MCKNIGHT</b>			2a. DATE OF DEATH Month <b>9</b> Day <b>7</b> Year <b>80</b>			2b. HOUR <b>225A</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>11-6-10</b>		6. AGE (In years lost birthday) <b>69</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Howard Co.</b> Md.	
10. CITY OR TOWN OF DEATH <b>Highland, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7020 Gardner Ln</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U.S. Gov</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>HIGHLAND</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>7020 GARDNER LANE</b>							
14. FATHER'S NAME First Middle Last <b>FRANK I Frey</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNE Derhake</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>578525695</b>		17. INFORMANT <b>Same as above</b> <b>Robert McKnight (Husband)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b> <b>1990</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized basenoma tosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>4 months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>80</b> , to <b>9/7</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9/6</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Hugh W. Frey, M.D.</b>				22c. DATE SIGNED <b>9/7/80</b>		22d. PHYSICIAN'S NAME (Type) <b>HUGH W. FREY, M.D.</b>	
22e. ADDRESS <b>11161 NEW HAMPSHIRE AVE Silver Spring Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/10/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>S.S. Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 11 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	3	6	3	0		
1 - FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Geneva M. Mercer										2a. DATE OF DEATH 9-17-80				2b. HOUR 10 <sup>30</sup> M				
3 SEX F			4 RACE W			5. DATE OF BIRTH 11-16-1909			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.									
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY XXXXXX home					
13a. STATE Maryland										13b. COUNTY PG		13c. CITY OR TOWN Columbia		13d. STREET ADDRESS 8302 Spruce Hill Dr. 6334 Cedar Lane				
14. FATHER'S NAME Charles Jones										15. MOTHER'S MAIDEN NAME Elizabeth McMillan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. 215-36-4754		17. INFORMANT ADDRESS Luther W. Mercer 8302 Spruce Hill Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR Collapse.</u> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SEPSIS.</u> (c) <u>C.V.A.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
MEDICAL CERTIFICATION																		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>9-11-80</u> , 19 <u>80</u> , to <u>9-12-80</u> , 19 <u>80</u> ; that (I) (we) lost saw the deceased alive on <u>9-12-80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE A. P. Allen, MD										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-18-80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A J A B S. SIDHU										22e. ADDRESS 5216 Lyngdale Rd. Columbia, Md 21046								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Sept 20, 1980		23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Bowie, Maryland								
24. FUNERAL DIRECTOR NAME Dorothy M. ...										ADDRESS Laurel Home		25a. DATE REC'D. BY REGISTRAR SEP 25 1980		25b. REGISTRAR'S SIGNATURE Dorothy M. ...				

James  
L. Jones  
3303 Spruce Hill Ave.  
Lynchburg, Va.

James L. Jones

James L. Jones

James L. Jones

James L. Jones

James L. Jones

Luther W. Mercer 3303 Spruce Hill Ave.

Lynchburg, Va.

Sept 20, 1950  
Lynchburg, Va.

SEP 20 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 3 6 3 1

1. DECEASED-NAME (Type or print) <b>SR. KATHLEEN MARY O'BRIEN, S.N.D.</b>			2a. DATE OF DEATH <b>9</b> Month <b>18</b> Day <b>80</b> Year			2b. HOUR <b>11:40 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>6-9-28</b>		6. AGE (In years lost birthday) <b>52</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>HOWARD COUNTY</b> — Md.	
10. CITY OR TOWN OF DEATH <b>ILCHESTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SRS. OF NOTRE DAME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>YOUTH MINISTRY</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — STATE <b>SRS. OF N.D.</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>ILCHESTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>LANDING ROAD</b>		14. FATHER'S NAME First Middle Last <b>JOHN THOMAS O'BRIEN</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>FLORENCIE G. O'BRIEN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>169-22-4473</b>		17. INFORMANT Address <b>SR. MARIAN SCHAECHTEL SRS. OF N.D.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>2050</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYELOGENOUS LEUKEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>May 18</b> , 19 <b>79</b> , to <b>Sept 18</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Sept 11</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Judith E Karp, MD</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9/20/80</b>	
22d. PHYSICIAN'S NAME (Type) <b>JUDITH E KARP, MD</b>				22e. ADDRESS <b>THE JOHNS HOPKINS ONCOLOGY CENTER</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-23-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ilchester</b>		23d. LOCATION (City or Town) (County) (State) <b>Ilchester Maryland</b>	
24. FUNERAL DIRECTOR <b>Ruck Towson Funeral Home, Inc., Towson, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 22 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Harry H. H. H.</b>	

MEDICAL CERTIFICATION

29

1





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 0 2 3 6 3 2	
1- FOR STATE REGISTRAR					REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <b>John S. O'Dell Sr</b>			2a DATE OF DEATH MONTH DAY YEAR <b>Sept 24, 1980</b>		2b HOUR M <b>AM</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov 6, 1915</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b>		MD.		
10 CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Trucking</b>		
12b KIND OF BUSINESS OR INDUSTRY <b>Business</b>		13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b CITY OR TOWN <b>Westminster</b>		
13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS <b>12 Hillside Court</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>late Worton O'Dell</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Leighton</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>215 03 3626</b>		17 INFORMANT ADDRESS <b>Mrs. Mona O'Dell 12 Hillside Ct. 21157</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <b>4140</b> IMMEDIATE CAUSE (a) <b>A. S. H. D.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (this hospital) attended the deceased from <b>9-27-80</b> to <b>9-24-80</b> , that (I) (we) lost saw the deceased alive on <b>9-27-80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.		22b SIGNATURE <b>Barbara Calin</b> DEGREE <b>M.D.</b>		
22c DATE SIGNED <b>9-25-80</b>		22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARBARA CALIN</b>		22e ADDRESS <b>3459 St. John's Lane E.C.</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Sept 27 '80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		
23d LOCATION CITY OR TOWN <b>Baltimore, Md.</b>		23e STATE <b>Md.</b>				
24 FUNERAL DIRECTOR NAME <b>Harry H Witzke</b>		24b ADDRESS <b>4112 Columbia Rd Ellicott Md</b>		25a DATE REC'D. BY REGISTRAR <b>SEP 26 1980</b>		
25b REGISTRAR'S SIGNATURE <b>[Signature]</b>						





John B. Dill et

Sept 27, 1902

Wife

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Howard County

U.S.A.

Howard County

Howard County General Hospital

Howard County General Hospital

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WILLIAM

WILLIAM

Howard County

Sept 27, 1902

Howard County

Howard County General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO. 8 0 2 3 6 3 3										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN HUGHES PARSONS</b>					2a. DATE OF DEATH MONTH <b>9</b> DAY <b>14</b> YEAR <b>80</b>					
3. SEX <b>M</b>					4. RACE <b>CAUCASION</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>13</b> YEAR <b>08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>COLUMBIA, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GENERAL HOSPITAL</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUSINESS MAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MAIL ORDER</b>	
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>CLARKSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>J.</b> MIDDLE <b>FRED</b> LAST <b>PARSONS</b>					15. MOTHER'S MAIDEN NAME FIRST <b>CATHARINE</b> MIDDLE <b>-</b> LAST <b>BURTON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT ADDRESS <b>WIFE - MAVIS PARSONS</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROBABLE PONTINE OR MIDBRAIN HEMORRHAGE</b> <b>431-</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6-7 HOURS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/14</b> , 19 <b>80</b> , to <b>9/14</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9/14</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John J. Blanch M.D.</b>					DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9/14/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN J. BLANCH, M.D.</b>					22e. ADDRESS <b>PATUXENT MEDICAL GROUP 5999 HARPERS FARM RD. COLUMBIA, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>9/14/80</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Patricia K. Brady</i>			



*[Faint, mostly illegible handwritten text on lined paper]*

Inventory Board      Exposed, No.      242, 100      242, 100

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELIZABETH POWELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/6/80</b>		2b. HOUR M <b>AM</b>		
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 25 25</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>55</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>10442 Greenmountain Circle</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Rutherford Mims</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Miller</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-18-1233</b>		17. INFORMANT ADDRESS <b>Fred D. Powell 10442 Greenmountain Circle</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> <b>1820</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>metastatic Endometrial Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>N/A.</b>							
19a. DATE OF OPERATION <b>N/A.</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/5/80</b> 19 <b>80</b> to <b>9/6/80</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9/5</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William Flowers MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/6/80.</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Flowers.</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sep 10 80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Pk</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Baltimore County, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Herbert E. Nutter 3035 W. North Ave</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 9 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Richard McBratney</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 3 6 3 5  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE	
EDGAR H. RAU, SR.		MALE		WHITE	
5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
MONTH DAY YEAR 9 12 01		79 YRS		HOWARD COUNTY MD.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. CITY OR TOWN OF DEATH	
MARYLAND		U.S.A.		COLUMBIA	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
HOWARD COUNTY GENERAL HOSPITAL		HTG. CONSULTANT		SCHUMACHER & SEILER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
MARYLAND A.A.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		244 TURNWOOD DRIVE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST JAMES TURNER RAU		FIRST MIDDLE LAST MAGGIE RICHARDSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		213-03-5357		LOIS S. HORKEY 244 TURNWOOD DRIVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest. Severe coronary Artery Disease.</u> <u>4254</u> DUE TO, OR AS A CONSEQUENCE OF <u>ischemic cardiomyopathy. Old MI, chronic CHF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Recurrent Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>? Digoxin Toxicity</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
-				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-9-80</u> to <u>9-17-80</u> , that (I) (we) last saw the deceased alive on <u>9-17-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>A. Divakaruni</u>		MD		9-17-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
A. Divakaruni		11085 Little Patuxent Pkwy, S102, Columbia, MD 21044			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		9/20/80		PARKWOOD CEMETERY	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. SIGNATURE	
NAME ADDRESS HUBBARD FUNERAL HOME 4107 WILKENS AVE.		SEP 19 1980		<u>P. J. Kelly</u>	



2591 1932



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 7/77  
(VR A 15 (4))

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 3 6 3 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Catherine Elizabeth Smith</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 13, 1980</b>			2b. HOUR <b>8 A.</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 30, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.			
10. CITY OR TOWN OF DEATH <b>Woodstock</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10400 CAVY LANE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Woodstock</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>10400 CAVY LANE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nimrod OREM</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216011518</b>		17. INFORMANT ADDRESS <b>Betty Waesche Reisterstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 A-S. CV. D</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8-4 1980 P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-4</b> , 19 <b>80</b> , to <b>9-13</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>8-4</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Barbara Calin</b> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>9-15-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARBARA CALIN</b>				22e. ADDRESS <b>3459 St. John's Lane EC</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-16-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Alphonsus Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodstock Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b> ADDRESS <b>Sykesville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Fitzgerald</b>			

MEDICAL CERTIFICATION

